Bureau of Health Care Quality and Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS773HSNF	A. BUILDING _____ B. WING _____	R 12/18/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DESERT LANE CARE CENTER	**660 DESERT LANE LAS VEGAS, NV 89106**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{Z 000}	Initial Comments Surveyor: 26907 This Statement of Deficiencies was generated as a result of a resurvey conducted at your facility on 12/18/09. The resurvey was conducted to ensure compliance with the survey findings of the State licensure survey conducted concurrently with the six month Special Focus Facility Medicare recertification survey on 9/22/09 through 9/29/09. The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. The census was 126 at the time of the revisit. Fourteen resident files were reviewed for compliance. The facility was found to be in substantial compliance. No further action is necessary concerning this report. Please retain this copy for your records.	{Z 000}		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE